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### HOSPITALIZATION AND TREATMENT OF THE MENTALLY ILL: OHIO'S NEW MENTAL HEALTH LAW

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The problems of hospitalization and treatment of the mentally ill are fraught with conflicting social interests and theoretical approaches. At one time the belief was prevalent that the sole purpose of hospitalization was custodial, to protect society from the mentally ill person and vice versa. Compulsory hospitalization or "commitment" procedures were directed against the "violently or dangerously insane," harmful to themselves or others. It is little wonder that mental health laws were closely analogous in language and operation to the criminal laws. Medical science has now disproved the pessimistic theory that the mentally ill are hopelessly incurable. With modern drugs and psychiatric treatment methods patients with mental illness respond to treatment more readily today, particularly when treated at an early stage. The differences between physical illness and mental illness becomes less distinguishable.

An important constitutional question which pervades any discussion of the hospitalization and treatment of the mentally ill is whether a person hospitalized has been denied "due process." If hospitalization is equated to imprisonment for criminal acts stringent procedural requirements exist to protect society and the individual from abuses. However, the "protection" of the public trial, the jury, and other like mechanisms proves cumbersome and traumatic in the mental health field. The modern concept of "due process" in relation to hospitalization of the mentally ill consists of substituting informal procedures and affording the patients greater protection during hospitalization

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with release provisions and speedy discharges and developing statutory rights.<sup>1</sup>

As a result of the growing awareness of the public and legislators concerning the true meaning of mental illness, its extent, and what can be done about it, ambitious programs have been undertaken by the various states, including Ohio, involving ever-increasing sums of money to combat "... the nation's number one public health problem. . . ."<sup>2</sup> Unfortunately, state laws equating mental illness with criminality in hospitalization and treatment procedures have gone far in defeating laudable intentions directed in other channels. The law, as is too often the case, lags behind. The inadequacy of existing state procedures has been a growing concern of the states, the national government, and leading authorities.<sup>3</sup>

In the past Ohio law relating to hospitalization and treatment procedures had many of the inadequacies of such laws generally. Any change in the law was piecemeal and needed amendments were slow. Statutes providing different admission procedures could be found in different chapters of the Ohio Revised Code. Of course any changes incorporated the unfortunate terminology used in the Ohio law. Amended Substitute House Bill No. 529, passed by the 104th General Assembly, enacted a much needed revision of the Ohio mental health law.<sup>4</sup> The Bill discards much of the formalism in admission procedures.

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<sup>1</sup> For a discussion of the history and new trends of the "due process" requirements in the mental health field see Kittire, "Compulsory Mental Treatment and the Requirements of 'Due Process'," 21 Ohio St. L.J. 28 (1960).

<sup>2</sup> Ross, "Commitment of the Mentally Ill: Problems of Law and Policy," 57 Mich. L. Rev. 945, 946 (1959).

<sup>3</sup> For a complete discussion of recent developments in this area see *id.* at 947. Since Professor Ross' article, another important development in this field has occurred. The American Bar Foundation Study has been published covering hospitalization and treatment procedures as well as related subjects under the title, Lindman and McIntyre, *The Mentally Disabled and the Law* (1961). This important and comprehensive study analyzes, classifies, and describes with critical evaluation the statutes and court decisions in the mental health field and gives various specific recommendations.

<sup>4</sup> There were two bills introduced in the 104th General Assembly to revise the hospitalization procedures. One was H. B. 529, introduced by Representatives Matia, Sweeny, Lady, Zona, Donnelly, Gorman and Sullivan. The bill was drafted by Mr. Matia in consultation with a special committee of the Cleveland Academy of Medicine. The second bill was H. B. 1002, introduced by Representatives Swanbeck, Calabrese and Donnelly. The latter bill was drafted by the staff of the Ohio Department of Mental Hygiene and Correction in consultation with Professor Webster Myers, Jr., Franklin University Law School. The two bills were consolidated into Substitute H. B. 529 in the House Public Welfare Committee. The drafting of the consolidation was the work of the authors and consultants listed above, a special subcommittee of the House Welfare Committee composed of Representatives Hoy, chairman, Calabrese, Donnelly, Hildebrand and Netzley, together with two committees of

It totally eliminates terminology which has connotations of criminality. It creates, for the first time in the Ohio law, a group of statutory, substantive rights of patients receiving treatment in mental hospitals. It repeals all prior sections effective October 25, 1961, and embodies the new law relating to hospitalization and treatment in a new chapter, Chapter 5122 of the Revised Code.

The new Ohio law in many respects is similar to the Draft Act Governing Hospitalization of the Mentally Ill,<sup>5</sup> a publication drafted by the Federal Security Agency as a model act to implement the recommendations of the Governors' Conference of 1950.<sup>6</sup> It is far from uniform legislation, however, since many changes were made to make the new law correspond to the peculiarities of local situations. Due to the long and complex nature of the new law, this article's scope is limited to a description, analysis, and evaluation of the new sections. Case decisions and comparative analysis of the new law with similar laws in other states will, for the most part, be omitted.

#### TERMINOLOGY AND DEFINITIONS

The new definition of a mentally ill individual, while similar to the old law, merely defines the general class of individuals to whom the various provisions of Chapter 5122 have potential application.<sup>7</sup> The finding of mental illness creates eligibility for voluntary admission. Such finding does not mean that the person is subject to enforced hospitalization. For compulsory hospitalization a finding must be made that the illness is of such degree that the individual is likely to injure himself or others if allowed to remain at liberty or that the individual lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization.<sup>8</sup> Thus, the issue in compulsory hospitalization has two parts: one, is the person mentally ill, and two, if so, is the mental illness of such degree as to satisfy the above legal criteria. In this respect the new law restricts the previous Ohio law, since the previous law required only a finding that the person was mentally ill.<sup>9</sup>

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the Ohio Probate Judges Association, the legislative review committee, Judge Woodside, chairman, and the Welfare Committee, Judge Barrett, chairman.

<sup>5</sup> U.S. Public Health Service, Pub. No. 51, a Draft Act Governing Hospitalization of the Mentally Ill (rev. ed. 1952). Other states using the Draft Act as a model for mental health law revision include Georgia, Idaho, Missouri, New Mexico, North Dakota, Oklahoma, South Carolina and Utah.

<sup>6</sup> 57 Ross, *op. cit. supra* note 2, at 947, 948.

<sup>7</sup> Ohio Rev. Code § 5122.01(A); compare Ohio Rev. Code § 5123.01(A) (1953), repealed.

<sup>8</sup> Ohio Rev. Code § 5122.01(B). The same requirements are necessary in Ohio Rev. Code §§ 5122.06, 5122.07, 5122.08 and 5122.09.

<sup>9</sup> See, *e.g.*, Ohio Rev. Code § 5125.32 (1953), repealed.

Both issues—whether the individual is mentally ill and whether such mentally ill individual is subject to hospitalization—are in the last analysis legal issues. In practice, however, the term “mental illness” is a medical term and the determination of whether a person is mentally ill should be based upon psychiatric examination and evaluation.<sup>10</sup> When psychiatric evaluation is available, great weight should be given to such evidence. In many communities within Ohio there are no psychiatrists available for examination of a person alleged to be mentally ill and the determination of hospitalization formerly was made solely by doctors and judges having no special psychiatric training or background. This unfortunate situation has been alleviated in the new law by making available to the courts the full psychiatric examination by the attending psychiatrist prior to a determination of indeterminate compulsory hospitalization.<sup>11</sup> Thus the new law places a proper emphasis upon the psychiatric and judicial evaluation of a person alleged to be mentally ill.

The definition of a mentally ill individual includes persons addicted to alcohol.<sup>12</sup> The major problem in the treatment of alcoholism is the potential increase in the number of patients under treatment in already inadequate facilities. Treatment of alcoholism in a mental hospital with no separate facilities for such care is of questionable effectiveness.<sup>13</sup> The new law makes provision for treating mentally ill persons outside the hospital. Where such methods are used in the treatment of alcoholism, desirable results are hoped for.

Other definitions of importance include the term “licensed physician” which means any physician licensed within the state of Ohio to practice medicine.<sup>14</sup> The definition requires neither psychiatric background nor special license. “Designated examiner” is a licensed physician registered by the Department of Mental Hygiene and Correction as specially qualified in the diagnosis of mental or related illnesses.<sup>15</sup> This permits courts to receive as evidence written medical reports from licensed physicians working in public hospitals. The new law contemplates that designated examiners will be physicians in mental hospitals licensed by the division of mental hygiene. “Hospital” means the mental or psychopathic wards of general hospitals, public or private. It also includes all hospitals licensed by the division of mental hygiene equipped to provide in-patient care and treatment for the men-

<sup>10</sup> See Weihofen, “The Definition of Mental Illness,” 21 Ohio St. L.J. 1, 15 (1960).

<sup>11</sup> See the discussion of Ohio Rev. Code § 5122.15, *infra*.

<sup>12</sup> Ohio Rev. Code § 5122.01(A).

<sup>13</sup> See 57 Ross, *op. cit. supra* note 2, at 952 fn. 29.

<sup>14</sup> Ohio Rev. Code § 5122.01(D).

<sup>15</sup> Ohio Rev. Code § 5122.01(E).

tally ill.<sup>16</sup> "Public hospital" is limited to the state supported hospitals.<sup>17</sup>

Under the old law a person afflicted with mental illness requiring psychiatric treatment or care faced the following procedure. When an affidavit had been filed in the probate court, the judge would issue a "warrant of detention." The person was then "detained" in a "place of detention" until the hearing. After the hearing, if it was determined that he was a mentally ill individual subject to treatment, the court "committed" him to an institution for the mentally ill. After "commitment" he became an "inmate."

The new law attempts as much as possible to remove this terminology from the area of criminality. The objective is to remove the unnecessary legal or social stigma attached to the use of legalistic phraseology inferring that a mentally ill person is guilty of a crime. Throughout the Revised Code "indeterminate hospitalization" replaces "commitment," "patient" replaces "inmate," "hospital" replaces "institution," and "warrant of detention" and "place of detention" have been dropped.

#### VOLUNTARY ADMISSIONS

The concept of voluntary admissions has been unanimously recognized by the authorities in the mental health field as the best possible procedure for the treatment and care of the mentally ill.<sup>18</sup> While various reasons are suggested why the voluntary admissions procedure is not used more often, the law in Ohio dealing with the procedure has been sufficiently restrictive to generally discourage wide use. Insofar as the law is concerned, the new law has eliminated much of the source of difficulty in relation to voluntary admissions.

The age limitation for persons who may apply for voluntary admission without the consent of a guardian is lowered from twenty-one years to eighteen years of age.<sup>19</sup> Young men and women of late teen years are generally sufficiently responsible and have a sufficient awareness of their condition that they should not be prohibited from entering a hospital by the mere reason of age alone. The situation is further aggravated by the many teenage men and women who are now transient and living within a local community, while the guardian or parents of such a person may be living out of the state. The provision of the old law that a minor under eighteen years of age or an adult incompetent may be admitted by the guardian or one having custody of such person is retained.<sup>20</sup>

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<sup>16</sup> Ohio Rev. Code § 5122.01(F).

<sup>17</sup> Ohio Rev. Code § 5122.01(G).

<sup>18</sup> See, e.g., Lindman and McIntyre, *op. cit. supra* note 3, at 107-08 (1961); Guttmacher and Weihofen, *Psychiatry and the Law* 305-08 (1952).

<sup>19</sup> Ohio Rev. Code § 5122.02.

<sup>20</sup> *Ibid.*

The requirement that an applicant for voluntary admission must be a resident of the hospital district where such application is made when the application is made to a public hospital has been modified by the new law to apply only to residents of the state.<sup>21</sup> This modification was necessary to clear up a difficult situation often created by the prior law. If a non-resident of the state of Ohio had applied to a public hospital for voluntary admission, he would necessarily have to be refused since he would have had to be a resident of the hospital district wherein the application was made and this requirement could not be met. Situations previously arose in which non-residents, while visiting or traveling in the state, became so emotionally ill that they needed and wanted treatment and yet were refused admission to public hospitals.<sup>22</sup>

The duty of the head of a public hospital to discharge a voluntary patient who has recovered or whose hospitalization he determines to be no longer advisable is clearly stated.<sup>23</sup> The prospective voluntary patient receives a clear indication from the law that he shall not be kept in the hospital for an extended period after his illness has been eliminated. This serves to assure the patient and will be an incentive to apply for voluntary admission. In addition the head of the hospital has the right to discharge any voluntary patient if to do so will contribute to the most effective use of the hospital.<sup>24</sup> This provision recognizes the difficulties in hospital supervision and administration where it may be impossible, facilities-wise, to keep a voluntary patient in the hospital.

In non-emergency cases public hospital officials have a statutory duty to admit voluntary patients subject to the availability of suitable accommodations.<sup>25</sup> A voluntary patient is admitted in all cases involving medical emergency. No method can be more destructive of a voluntary admissions policy than a systematic refusal of voluntary applications by hospital officials. Some hospital officials' non-approval

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<sup>21</sup> *Ibid.*

<sup>22</sup> While the new law allows the non-resident to be admitted as a voluntary patient, the existing rules on state financial responsibility for non-residents have not been changed. Thus a non-resident would be admitted where he could pay for hospitalization or where he is a resident of a state which, like Ohio, has enacted the Interstate Compact on Mental Health. In the latter case, he would probably remain in the Ohio hospital for short-term treatment, or if the period of treatment is lengthy, he might be transferred to his state of residence under Article III of the Compact. See Ohio Rev. Code §§ 5123.60 and 5123.63 (Page Supp. 1960).

<sup>23</sup> Ohio Rev. Code § 5122.02.

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.* Under the prior law hospital officials had absolute discretion in admitting or refusing voluntary applicants. See Ohio Rev. Code § 5123.44 (1953), repealed.

of the patient's right of release upon request has been suggested as one cause of such refusals.<sup>26</sup> The new law expresses a legislative policy that voluntary admission applicants shall not be denied admission without good cause. With this new statutory provision and strong adherence to the principles behind the statute by the division of mental hygiene, there is a probability that such an obstacle to voluntary admissions, if it exists, will be corrected.

The requirement that a medical certificate accompany the application has been eliminated.<sup>27</sup> Such red tape prerequisites have generally been considered as unreasonable hindrances to voluntary admissions.

The rights of a voluntary patient while in the hospital have been vastly expanded under the new law.<sup>28</sup> On this point the new law is in accord with the recommendations of leading authorities that clear statutory guarantees be provided so that legal and civil rights shall not be abridged except where medically necessary. This is an incentive for the increased use of the voluntary admissions approach.<sup>29</sup> The voluntary patient's right to release upon written application is retained with several important modifications. The request for release may be made by the patient, the patient's parent, spouse or adult next of kin.<sup>30</sup> Permitting persons other than the patient to request release gives added assurance to the prospective patient that he may not be held in a hospital without judicial action against his wishes. An important qualification on the right of persons other than the patient to request release is the provision that when such request is made, release may be conditioned upon the patient's consent.<sup>31</sup> In the event of a disagreement the patient should have the right to remain in the hospital.<sup>32</sup> If the patient is under 18 years of age, his request for release is conditioned upon the consent of his guardian. The last important qualification on the right to release is the provision for commencement of judicial proceedings for hospitalization by the hospital authority. This is restricted to those situations where release would be "... unsafe for the patient or others. . . ."<sup>33</sup> If the patient is potentially dangerous to himself or others, the right to

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<sup>26</sup> See Lindman and McIntyre, *op. cit. supra* note 3, at 110.

<sup>27</sup> Compare Ohio Rev. Code § 5122.02 with Ohio Rev. Code § 5123.44 (1953), repealed.

<sup>28</sup> These rights are discussed in the part dealing with Patients' Rights and Competency, *infra*.

<sup>29</sup> See, e.g., Lindman and McIntyre, *op. cit. supra* note 3, at 111; Ross, "Hospitalization of the Voluntary Patient," 53 Mich. L. Rev. 353 (1955).

<sup>30</sup> Ohio Rev. Code § 5122.03.

<sup>31</sup> Ohio Rev. Code § 5122.03(A)(1).

<sup>32</sup> Draft Act, *op. cit. supra* note 5, at 21.

<sup>33</sup> Ohio Rev. Code § 5122.03(A)(3). Under the old law release could be postponed in all cases. Ohio Rev. Code § 5123.45 (1953), repealed.

hospitalize the patient should be treated substantially the same whether the patient is in or out of the hospital.<sup>34</sup> A statutory duty is imposed upon the head of the hospital to provide reasonable means and arrangements for informing voluntary patients of the right to release and assisting them in making the request for release.<sup>35</sup> Without such provision the availability of the right may have little or no real meaning.<sup>36</sup>

A difficult problem arises in determining the length of time which should elapse after a request for release before the hospital official must release the patient or institute judicial proceedings.<sup>37</sup> An eloquent argument was made by several psychiatrists that a rather long period should be permitted to allow the hospital officials to fully evaluate the case and to give the patient a cooling-off period. Often the patient will change his mind after reflection, particularly when he is in an early period of adjustment. The new law provides for a ten day cooling-off period.<sup>38</sup>

An addition in the new law with respect to patients' rights which is peculiar to voluntary patients is the immunity of a voluntary patient from judicial proceedings for hospitalization.<sup>39</sup> If the prospective voluntary patient considers voluntary hospitalization as a first step in judicial hospitalization, this is a natural deterrent to the use of the procedure. Under the new law a voluntary patient may retain his status so long as he desires, and judicial hospitalization cannot be commenced until a request for release is presented. This provision places no limitation upon a guardianship proceeding in the event such is deemed necessary to protect a patient's estate.

#### INVOLUNTARY NONJUDICIAL HOSPITALIZATION

Involuntary hospitalization refers to hospitalization procedures which are not originally initiated by the patient or his guardian.<sup>40</sup> Sec-

<sup>34</sup> Similarly, if the patient can be safely released, there is no good reason to hold him. Subsequent judicial proceedings may be commenced after the patient leaves the hospital.

<sup>35</sup> Ohio Rev. Code § 5122.03(B).

<sup>36</sup> Lindman and McIntyre, *op. cit. supra* note 3, at 113; 53 Ross, *op. cit. supra* note 26, at 377-80. The American Bar Foundation Study indicates only three states have the important statutory duty of informing voluntary patients of their right to release upon request. Ill. Rev. Stat. ch. 91½, § 5-2 (1950); La. Rev. Stat. §§ 28:51, 28:98.1 (Supp. 1958); Tex. Mental Health Code art. 5547-24(a) (Supp. 1958).

<sup>37</sup> The Draft Act provides 48 hours. Draft Act, *op. cit. supra* note 5, at 5.

<sup>38</sup> Ohio Rev. Code § 5122.03(A)(3). Several authorities have suggested a similar time limit would be appropriate. See Ross, "Hospitalizing the Mentally Ill—Emergency and Temporary Commitments," 1955-1956, *Current Trends in State Legislation* 483, 484; Curran, "Hospitalization of the Mentally Ill," 31 N.C. L. Rev. 274, 279 (1953).

<sup>39</sup> Ohio Rev. Code § 5122.03(B).

<sup>40</sup> See Lindman and McIntyre, *op. cit. supra* note 3, at 108-09; Draft Act, *op.*



tion 5122.05 sets forth the basic authority of all hospitals and the duty of the public hospital in medical emergency situations to receive patients pursuant to involuntary hospitalization procedures. A mandatory duty is placed on the public hospital to receive patients in "... psychiatric medical emergencies. . . ." One of the purposes of this new duty is to effectuate the legislative intent that emotionally ill persons will be taken to a facility where treatment and proper care can be given. The proper operation of this method requires the full cooperation of the law enforcement agencies. If they have a dangerously ill person on their hands, they are going to put him somewhere—if not in a hospital, then in a jail. Specific authority is given to hospitals to admit, observe, diagnose, care for and treat all involuntarily hospitalized patients.<sup>41</sup> This has corrected an ambiguity in the old law which did not spell out the authority of hospitals to act other than as custodian in emergency cases.<sup>42</sup> In many instances the hospital officials followed the safe approach and did not treat emergency cases even though the situation strongly called for treatment.

Section 5122.06 is a new hospitalization procedure in Ohio. It provides for hospitalization by medical certification where a person is in need of treatment and is incapable of or does not wish to seek admission voluntarily but would not object if others sought his admission.<sup>43</sup> The use of this procedure is conditioned upon the lack of objection in writing by the prospective patient.<sup>44</sup> The procedure may be initiated by a "... friend, relative, spouse, or guardian of the individual, a health or public welfare officer, or the head of any institution in which such individual may be. . . ."<sup>45</sup> There is no requirement that the party making the application bring the individual to the hospital. As an example of the use of this procedure, the head of a non-mental hospital could make application with respect to a patient who, while being treated for some physical illness, has become mentally ill, and could arrange directly for the patient's transfer to a mental hospital or could call upon a friend or relative of the patient to effect the transfer.<sup>46</sup>

The medical certification, which must state that the individual has been examined and is in such condition that he requires hospitalization,

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*cit. supra* note 5, at 22. Actual compulsion need not be present. For example, hospitalization cannot be effected under Ohio Rev. Code § 5122.06 over the written protest of the prospective patient.

<sup>41</sup> Ohio Rev. Code § 5122.05.

<sup>42</sup> See Ohio Rev. Code § 5123.22 (1953), repealed.

<sup>43</sup> The non-protested admission is a part of the Draft Act and is now employed by fourteen states. Lindman and McIntyre, *op. cit. supra* note 3, at 35.

<sup>44</sup> Ohio Rev. Code § 5122.06.

<sup>45</sup> Ohio Rev. Code § 5122.06(A).

<sup>46</sup> Draft Act, *op. cit. supra* note 5, at 23.

must be accompanied by two medical reports and signed by two licensed physicians.<sup>47</sup> To prevent possible misuse of the procedure, one of the certifying physicians must have no financial connection with the hospital to which the application is made. By implication one of the physicians may be a member of the hospital staff. The requirement is fulfilled if the individual has been certified by his physician and then, upon arrival at the hospital, is examined and certified by a physician of the hospital staff. To prevent the use of stale certificates, a certificate cannot be used to hospitalize an individual after the expiration of ten days from the date of the examination.<sup>48</sup> The condition of the individual, in order for the non-protested procedure to be used, must meet the conditions for judicial hospitalization, *i.e.*, he must be dangerous or lack the capacity to make responsible decisions with respect to hospitalization.<sup>49</sup>

Section 5122.18 and Section 5122.24 directly relate to and qualify the non-protest involuntary procedure described above and should be understood as a part of that procedure. These sections apply to and are equally important in the other nonjudicial involuntary hospitalization procedures.<sup>50</sup> Section 5122.24 relates to the patient's right to release upon written request.<sup>51</sup> The written request may be made by the patient or "... by his legal guardian, spouse, or adult next of kin. . . ."<sup>52</sup> Permitting persons outside the hospital to request the patient's release helps insure that his freedom will not be denied by misuse of the non-judicial procedures. A written request is required in order to avoid problems of evidence. The patient must be released within ten days after receipt of the request.<sup>53</sup> The policy factors behind allowing a ten-day cooling-off period prior to release are similar to the factors permitting the same delay in release of voluntary patients.<sup>54</sup> During the ten day period the head of the hospital may certify to the probate court that the release "... would be unsafe for the patient or others. . . ."<sup>55</sup> If such certification is made, release is postponed,<sup>56</sup> and appropriate judicial proceedings must be commenced within ten days.<sup>57</sup>

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<sup>47</sup> Ohio Rev. Code § 5122.06(B).

<sup>48</sup> *Ibid.*

<sup>49</sup> *Ibid.* See the discussion relating to note 8, *supra*.

<sup>50</sup> The requirements of Ohio Rev. Code § 5122.18 and § 5122.24 must be met when hospitalization is under Ohio Rev. Code §§ 5122.07, 5122.08, 5122.09, and 5122.10.

<sup>51</sup> Compare Draft Act, *op. cit. supra* note 5, at 14, 33.

<sup>52</sup> Ohio Rev. Code § 5122.24.

<sup>53</sup> *Ibid.*

<sup>54</sup> See the discussion relating to notes 33, 34, *supra*.

<sup>55</sup> Ohio Rev. Code § 5122.24.

<sup>56</sup> Ohio Rev. Code § 5122.32.

<sup>57</sup> Ohio Rev. Code § 5122.24.

A mandatory duty is imposed upon the head of the hospital to inform the individual of his right to release.<sup>58</sup>

The release provisions relating to involuntary hospitalization have real meaning. They afford true protection for the individual who should not be in the hospital and wants to be released. They also provide a substantive answer to constitutional objections since upon request of the patient release or immediate judicial inquiry is effected.<sup>59</sup>

Section 5122.18 provides that in nonjudicial involuntary hospitalization procedures notice of hospitalization shall be immediately given "... to the patient's legal guardian, spouse, or next of kin, if known." Thus a patient cannot be secretly taken into a hospital without judicial inquiry and held incommunicado without notification to those who are dear to him and can help him. The requirement of notice to those outside the hospital also completes the protection of the release provisions since the patient's presence in the hospital is made known to those who can request his release under Section 5122.24.

Situations may arise where the Section 5122.06 certification has been made and the person objects but an element of danger exists. In these circumstances, if the certification "... states a belief that the individual is likely to injure himself or others if allowed to remain at liberty ..." legal compulsion may be used to hospitalize the person.<sup>60</sup> The provision does not require that an immediate emergency situation has arisen so long as the real possibility of a future emergency exists. The filing of such a certification with a public hospital or the probate court authorizes the head of the hospital<sup>61</sup> or the judge to order the appropriate authorities to transport the person to a hospital. Under this section and in all emergency hospitalization procedures, a general hospital not licensed by the division of mental hygiene may be used.<sup>62</sup> However, a limitation is placed on an unlicensed hospital in the hospitalization of emergency cases in that at the end of five days the individual must be transferred to a licensed hospital or be discharged.<sup>63</sup> The use of unlicensed hospitals for emergency situations broadens the possible facilities available to the authorities and thus lessens the likelihood that jails and other undesirable places will be used for detention.

Sections 5122.08, 5122.09, and 5122.10 are the new emergency

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<sup>58</sup> *Ibid.* See note 36, *supra* and the discussion relating thereto.

<sup>59</sup> See Lindman and McIntyre, *op. cit. supra* note 16, at 35.

<sup>60</sup> Ohio Rev. Code § 5122.07.

<sup>61</sup> Ohio Rev. Code § 5122.07 reads "... commissioner of the division of mental hygiene or his designee ..." but the head of a public hospital may be the commissioner's designee for the purpose of ordering a person transported to a hospital pursuant to Ohio Rev. Code §§ 5122.07 and 5122.09.

<sup>62</sup> Also see Ohio Rev. Code §§ 5122.07, 5122.08 and 5122.10.

<sup>63</sup> Ohio Rev. Code § 5122.19.

admission provisions.<sup>64</sup> Section 5122.08 is the standard emergency procedure to deal with critical situations. Hospitalization pursuant to this procedure requires an application, supported by a certification by a licensed physician, stating that the individual is likely to cause injury to himself or others if not immediately restrained. Because of the emergency nature of the situation, the application may be made by any person. To avoid misuse of stale certificates, the certificate expires three days after the date of examination. Section 5122.08 changes the old law in two important respects. Under the old law no medical certificate is needed.<sup>65</sup> The requirement of a medical certificate, when the time is available to obtain one, is a necessary safeguard to the individual when compulsory hospitalization is forced upon him. The other change is the removal of the time limitation of five days that the individual can be detained under the emergency procedure.<sup>66</sup> When a person has become mentally ill to the extent that he becomes immediately dangerous, it would seem that a hospital, where he can receive proper treatment, is the proper place for the person. If the patient is in the hospital and does not object, it seems unnecessary that he must either be released within a very short time, when treatment would probably be ineffective, or be subjected to judicial hospitalization with the attendant social stigma and difficulties. Thus the removal of the time limitation seems to be in line with more modern hospitalization procedures, so long as additional safeguards are provided to insure that the emergency procedure has not been misused.

In addition to the patient's right to release upon request,<sup>67</sup> a duty is placed upon the hospital to hold an examination within five working days after the date of admission of patients admitted pursuant to any of the emergency procedures.<sup>68</sup> Section 5122.09 provides procedure for legal compulsion, when necessary, to transport an individual to the hospital who has been certified in accordance with Section 5122.08.<sup>69</sup>

Section 5122.10 is designed for the emergency situation where time will not permit a certification or other procedural steps. For example, a person may become so violent and dangerous at night or on a week end as to threaten immediate harm if allowed to remain at liberty for the time necessary to obtain a certification. In this event any public health or police officer, doctor or sheriff acting upon his own

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<sup>64</sup> Replacing Ohio Rev. Code § 5123.22 (1953), repealed.

<sup>65</sup> See *id.*

<sup>66</sup> See *id.*

<sup>67</sup> See the discussion relating to notes 48-56, *supra*.

<sup>68</sup> Ohio Rev. Code § 5122.19. The duty is enforced by requiring release of the patient if the examination is not held within the prescribed time.

<sup>69</sup> The procedure is the same procedure used under Ohio Rev. Code § 5122.07.

belief may transport the person to a hospital.<sup>70</sup> He may do so under two circumstances: where he believes that the person is likely to injure himself or others if allowed to remain at liberty pending certification by a licensed physician; and where certification has been made but has not been filed as required by Section 5122.07 or 5122.09 and the officer believes that the individual is likely to injure himself or others if allowed to remain at liberty pending such filing and order as provided in those sections.<sup>71</sup> The procedure is desirable and necessary in order to keep psychotic emergency cases out of undesirable places of detention such as jails.<sup>72</sup>

The major problem with emergency procedures where an officer or sheriff may act upon his own initiative in transporting a dangerously and violently emotionally ill person to a hospital is the general nonuse of such sections. Possible reasons for the nonuse are either that the procedures upon arrival at the hospital, so far as the officer is concerned, are too burdensome and complicated or that the use has been discouraged by systematic refusals by the hospital officials to admit the patient. Another reason for nonuse of such procedures may be the fear of the transporting official that he may be subjected to civil liability in the event that he is wrong in his layman's diagnosis. These three objections have been minimized by the new law. A mandatory duty is placed upon the public hospital to receive patients in emergency psychiatric situations.<sup>73</sup> The procedure after transporting the person to a hospital has been simplified to the mere giving of a statement stating the circumstances under which the individual was taken into custody and the reasons for the officer's belief that hospitalization is necessary.<sup>74</sup> Upon the showing of good faith, the transporting official is relieved from any criminal or civil liabilities which may result from an incorrect diagnosis.<sup>75</sup> The new statute sets forth a definite statement of legislative intent that emergency cases should be admitted to hospitals rather than jails and sets up a simplified procedure for admission of these cases. Whether this ideal can be realized in practice depends largely on close and continued cooperation between local enforcement agencies and the hospitals.

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<sup>70</sup> Ohio Rev. Code § 5122.10.

<sup>71</sup> *Ibid.*

<sup>72</sup> The prior law authorized the use of jails as a place of detention for short durations. Ohio Rev. Code 5123.22 (1953), repealed. This authorization is eliminated and the use of jails as places of detention is authorized only in extreme urgencies. Ohio Rev. Code § 5122.17. When the urgency ends the authorization ends.

<sup>73</sup> Ohio Rev. Code § 5122.05.

<sup>74</sup> Ohio Rev. Code § 5122.10.

<sup>75</sup> Ohio Rev. Code § 5122.34.

## JUDICIAL HOSPITALIZATION

Judicial hospitalization is commenced by the filing of an affidavit. Any person or persons may file the affidavit.<sup>76</sup> The form of the affidavit and the information it must contain rests with the discretion of the division of mental hygiene.<sup>77</sup> The affiant may file on the basis of information instead of actual knowledge, but the probate court may refuse an affidavit based on information.<sup>78</sup> The court may also refuse an affidavit until such time as it is accompanied by a certificate from a licensed physician that the individual is mentally ill and should be hospitalized.<sup>79</sup> These latter provisions are aimed at groundless or malicious applications. If the judge has doubt that the affiant is in good faith or doubts the affiant's ability to reasonably evaluate another's actions or has other suspicions, he may require further proof of the condition of an alleged mentally ill person before proceeding further. The certification requirement is generally considered to be a desirable and effective method of preventing unnecessary proceedings.<sup>80</sup>

Upon receipt of the affidavit the judge may require the individual to be hospitalized immediately where he "... is likely to injure himself or others, . . . or needs immediate hospital treatment."<sup>81</sup> The prior law required immediate detention by means of a warrant upon receipt of an affidavit.<sup>82</sup> Thus an individual would be jailed or hospitalized immediately prior to any hearing without compelling reason. The judge should have the discretion to determine under what circumstances immediate detention is necessary, and the new law makes provision for such discretion.

After judicial proceedings have been initiated, the court is required to give notice to various interested parties of any hearings.<sup>83</sup>

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<sup>76</sup> Ohio Rev. Code § 5122.11. Under the prior law persons who could file an affidavit were limited to certain classes, *i.e.*, residents of the country. Ohio Rev. Code § 5123.18 (1953), repealed. As a consequence, court actions have arisen on the sole ground that the affiant was not a county resident. It hardly seems probable that residence would have relevance on the issue of mental illness, but this could have been the decisive factor in determining whether a patient should be released from the hospital, regardless of the mental condition of the patient involved.

<sup>77</sup> Ohio Rev. Code § 5122.11. The old law required specific information. Ohio Rev. Code § 5123.18 (1953), repealed.

<sup>78</sup> Ohio Rev. Code § 5122.11.

<sup>79</sup> *Ibid.*

<sup>80</sup> See Lindman and McIntyre, *The Mentally Disabled and the Law* 24 (1961); Ross, "Commitment of the Mentally Ill: Problems of Law and Policy," 57 Mich. L. Rev. 945, 967 (1959).

<sup>81</sup> Ohio Rev. Code 5122.11. The mandatory "arrest" has received strong criticism. See Curran, *op. cit. supra* note 38, at 281-82.

<sup>82</sup> Ohio Rev. Code § 5123.19 (1953), repealed.

<sup>83</sup> Ohio Rev. Code § 5122.12.

The notice requirements are substantially the same as the old law with one important qualification. The old law provides that if the court has reason to believe that notice to the patient would be harmful to his condition, notice to such patient may be omitted.<sup>84</sup> While omission of notice under these circumstances has been considered desirable, serious constitutional questions have been raised where notice has been omitted.<sup>85</sup> The new law provides that notice to the patient may be dispensed with only if a guardian ad litem is appointed for receipt of such notice.<sup>86</sup> Where a guardian ad litem is appointed, he continues to represent the person throughout the action on the affidavit.

Section 5122.13 introduces a new method of providing the court with more complete information and evidence in cases of mental illness. It provides that upon receipt of an affidavit or reliable information the probate court may order an investigation by court-appointed social workers or by the county welfare department.<sup>87</sup> This investigation may be useful in a variety of situations. For example, in committee hearings evidence was presented that in several instances doctors treating patients for physical difficulties became aware that the patient was mentally ill and needed treatment. The doctor, for one reason or another, could not or would not go through the procedures necessary for hospitalization. The doctor would call the probate court and request help which often was refused unless the doctor initiated commitment proceedings. The patient would not be hospitalized and tragedy often resulted. Under the new law the probate court has the authority and facilities to investigate such situations and initiate hospitalization proceedings where necessary. Another of the expected common uses of the new procedure is to investigate suspicious affidavits.

After the proceedings have been commenced and notice given, the probate court appoints at least one licensed physician to examine the individual in an atmosphere not likely to have an injurious effect on his mental condition.<sup>88</sup> In two situations the court need not appoint a physician for examination. If the court has previously required a medical certification to accompany the affidavit, that medical report

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<sup>84</sup> Ohio Rev. Code § 5123.21 (Page Supp. 1960), repealed.

<sup>85</sup> See Lindman and McIntyre, *op. cit. supra* note 80, at 25 fn. 92.

<sup>86</sup> Ohio Rev. Code § 5122.12. Only Washington has a similar provision for protection of the patient. See Wash. Rev. Code § 71.02.140 (1958). In 1959 Professor Ross suggested that the Washington statute is the only adequate one in this respect. 57 Ross, *op. cit. supra* note 80, at 969.

<sup>87</sup> Ohio Rev. Code § 5122.13. Only Minnesota has a similar statute. See Minn. Stat. § 525.752 (1959). Such a provision has been recommended as worthwhile. Ross, *op. cit. supra* note 80, at 968.

<sup>88</sup> Ohio Rev. Code § 5122.14.

may be used.<sup>89</sup> Where the individual is already in the hospital, the court may use the written report of the head of the hospital as medical evidence.<sup>90</sup>

The hearing is required to be held in a physical setting not likely to be injurious to the patient. This would include the hospital or the patient's home. The patient is not required to be present if such presence would be injurious to him.<sup>91</sup> These new provisions provide needed changes because of the often traumatic effect of the hearing. As one writer stated:

It is widely recognized that when the formal hearing is conducted in public with the patient compelled to be present the cumulative effect of the whole procedure is often medically harmful. The paranoiac is already suffering from the feeling that society is conspiring to punish him. If he is required to sit in a courtroom and listen to his physician and family testify against him, the experience will confirm his suspicions and make psychiatric treatment much more difficult.<sup>92</sup>

Other new provisions include the right to present and cross-examine witnesses, the power of the court to receive all evidence it deems material, the notice to the patient of his right to secure counsel and the power of the court to appoint counsel.<sup>93</sup>

The new procedure subsequent to the hearing is a departure from existing mental health laws and perhaps will be the most beneficial aspect of the new law. After completion of the hearing the court has two alternatives. It discharges the person if it finds such person is not mentally ill. It orders the person to a temporary observation and treatment period not to exceed ninety days if it finds there is probable cause to believe such person is mentally ill and in need of treatment.<sup>94</sup> The

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<sup>89</sup> *Ibid.* Only Illinois has a similar option. See Ill. Rev. Stat. ch. 91½ (1957). While a medical examination is desirable so the court will have medical evidence at the hearing, if the court has required a medical examination prior to accepting the affidavit there is no real need for a duplication unless the case is contested. See 57 Ross, *op. cit. supra* note 80, at 968.

<sup>90</sup> Ohio Rev. Code § 5122.14.

<sup>91</sup> Ohio Rev. Code § 5122.15.

<sup>92</sup> 57 Ross, *op. cit. supra* note 80, at 970.

<sup>93</sup> Ohio Rev. Code § 5122.15. The Draft Act and the American Bar Foundation study suggest every patient should be represented by counsel. Lindman and McIntyre, *op. cit. supra* note 80, at 29. Such a provision was objected to as an unnecessary expense since the majority of cases are uncontested. The issue has been raised whether patients have a real chance to contest the case without the aid of counsel. See 57 Ross, *op. cit. supra* note 80 at 971.

<sup>94</sup> Ohio Rev. Code § 5122.15. Under the prior law an observation period was permissive. See Ohio Rev. Code § 5123.23 (Page Supp. 1960), repealed. Ohio Rev. Code § 5122.15 provides "... the court may order ..." and upon first impression



mandatory temporary period should ultimately help to reduce the number of patients in mental hospitals. Many patients in mental hospitals are there due to the aging process.<sup>95</sup> Often in cases of senility, as well as other types of mental illnesses, relatively short treatment periods may permit a patient to become sufficiently recovered so that continued hospitalization in a mental hospital is no longer justified. The past tendency, to continue judicial hospitalization beyond that time, should be lessened because a re-evaluation after ninety days is automatic. For the temporary period the court may order the patient to a public hospital, private hospital, United States government agency, community mental hygiene clinic or private psychiatrist.<sup>96</sup> The use of private facilities is conditioned upon the consent of the facility. The expanded facilities available to the court gives it wide discretion to meet the specific situation with the desired course of action. Of course, potentially, the person may stay in the community and continue normal social and business relations during this period. This also envisions the increased future use of roving psychiatric units, temporary care hospitals, and local mental health clinics to treat mentally ill persons in the early stages of their illness.<sup>97</sup>

At any time during the observational and treatment period the patient may apply for voluntary admission to a hospital, and the proceedings will be terminated upon admission.<sup>98</sup> The application will be treated according to the rules previously discussed relating to voluntary admissions. This provision should add great impetus to patients entering the treatment situation on a voluntary basis. Its use will reduce the stigmas attached to judicial hospitalization and prevent the result-

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this may erroneously seem permissive. However, only two alternates are indicated after completion of the hearing, and the legislative intent was clear that only two alternatives at that stage existed. The term "may" is only used to indicate the court has alternate facilities available. The term "may" is used in the same manner subsequently in section 5122.15 when referring to the court's procedure after the temporary period has expired and was used in the same manner in Ohio Rev. Code § 5123.23 (Page Supp. 1960), repealed.

<sup>95</sup> See 53 Ross, *op. cit. supra* note 29, at 392; Whitmore, "Comments on a Draft Act for the Hospitalization of the Mentally Ill," 19 Geo. Wash. L. Rev. 512, 528 (1951).

<sup>96</sup> Ohio Rev. Code § 5122.15.

<sup>97</sup> Presently Ohio is among the leading states in the use of temporary case hospitals. See 1955-56 Ross, *op. cit. supra* note 38, at 500; Elder and Benimoff, "The Purpose of Receiving Hospitals," 47 Ohio St. Med. J. 531 (1951).

<sup>98</sup> Ohio Rev. Code § 5122.15. Automatic termination is not specifically provided but Ohio Rev. Code § 5122.03 requires that no judicial proceedings will be commenced with respect to a voluntary patient. Automatic termination is further supported by the language of Ohio Rev. Code § 5122.15: "If, at the end of the ninety-day period, there has been no disposition of the case . . . by . . . voluntary admission . . . ."

ing loss of competency. Certainly the provision is a worthy experiment in the mental health field.

During or at the expiration of the temporary period, the facility reports its findings to the court, and the court may discharge the patient or order indeterminate hospitalization.<sup>99</sup> The court is authorized to use the facility's report as evidence, but the final determination remains with the court. To order indeterminate hospitalization the court must find that the patient is "... a mentally ill individual subject to hospitalization by court order. . . ."<sup>100</sup> Indeterminate hospitalization may be ordered to a public hospital, government agency, private hospital, county home, relative, friend or any other suitable place.<sup>101</sup>

#### PATIENT RIGHTS AND COMPETENCY

The new law introduces into Ohio the modern concept of statutory protection of rights of a hospitalized patient. When a patient is being treated in a mental hospital, restrictions must be placed on certain rights because of the very nature of the illness, *i.e.*, the right to receive visitors or communicate with others. In Ohio the extent of these restrictions in the past has depended upon individual hospital procedure. The new law places statutory limitations upon the hospital authorities. Aside from safeguarding the patient from hospital abuses the statutory guarantees have the purpose of creating a sympathetic public attitude toward hospitalization and mental hospitals generally.<sup>102</sup> The statutory guarantees enacted by the new law correspond generally with better mental hospital administration.

Section 5122.27 provides that every patient shall be entitled to humane care and treatment and, to the extent possible, care and treatment in accordance with the highest medical standards. The maintenance of such standards are primarily legislative problems, not a hospital problem alone.

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<sup>99</sup> Ohio Rev. Code § 5122.15. The statute does not specifically state the facility may return the patient to the court with the recommendation of indeterminate hospitalization prior to the expiration of the temporary period but this is necessarily implied. The statute does authorize the court to order indeterminate hospitalization prior to the expiration of the temporary period. The purpose of this authorization is to end the temporary period when the court deems such is advisable. Many situations may arise where it is advisable that the facility recommend indeterminate hospitalization prior to the expiration of the temporary period, *i.e.*, the patient may be treated and observed while remaining in the community and he may become uncooperative or his condition may deteriorate.

<sup>100</sup> Ohio Rev. Code § 5122.15. For the definition see the discussion relating to note 7, *supra*.

<sup>101</sup> Ohio Rev. Code § 5122.15.

<sup>102</sup> 57 Ross, *op. cit. supra* note 80, at 980; U.S. Public Health Service, Pub. No. 51, A Draft Act Governing Hospitalization of the Mentally Ill (rev. ed. 1952).

Section 5122.28 requires that mechanical restraints shall not be used unless required by the medical needs of the patient, and any use of such restraints shall be made part of the clinical record of the patient. Whether mechanical restraints upon the movements of patients are ever justified has been strongly doubted.<sup>103</sup> However, the use of restraints seems a medical reality so long as the state mental health funds are insufficient to provide adequately for the care and treatment of the mentally ill.<sup>104</sup> The new provision adds a needed control over possible abusive use of mechanical restraints.

Section 5122.29 gives broad protection to the patient's rights of communication and visitation. So long as the rights do not conflict with orderly hospital functioning or with the patient's best interest, the patient is entitled to communicate and to receive visitors freely. Any limitations imposed upon those rights due to such conflict must be made a part of the clinical record of the patient.<sup>105</sup> In addition, the patient has the unrestricted or absolute right to communicate by sealed letter with the division of mental hygiene and the probate court and to communicate by any means with his physician and attorney.<sup>106</sup> The patient has the absolute right to receive visits from his personal physician.<sup>107</sup> The unrestricted rights of the patient are effective deterrents to potential "railroading." A patient cannot lawfully be held incommunicado and his right of correspondence extends to his most effective relief, his attorney.

Section 5122.31 provides that patient records shall be kept confidential except under certain circumstances. This requirement includes hospital and court records. An exception is made for court journal entries and docket entries, presumably for the benefit of those concerned with property and contract problems of patients since judicial indeterminate hospitalization still results in incompetency.<sup>108</sup> Records may be disclosed in the following circumstances: upon consent of the identified patient and approval of the request by the hospital or court; when necessary in court proceedings, *i.e.*, incompetency proceedings; and when necessary to carry out the provisions of Chapter 5122.<sup>109</sup> This section is designed ". . . to protect patients and those whose

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<sup>103</sup> The American Bar Foundation study presents a strong argument against the use of mechanical restraints. Lindman and McIntyre, *op. cit. supra* note 80, at 145-47. The Draft Act suggests restraints are permissible in some cases. Draft Act, *op. cit. supra* note 102, at 34.

<sup>104</sup> 57 Ross, *op. cit. supra* note 80, at 1002-03.

<sup>105</sup> Ohio Rev. Code § 5122.29.

<sup>106</sup> *Ibid.*

<sup>107</sup> *Ibid.*

<sup>108</sup> See Ohio Rev. Code § 5122.36.

<sup>109</sup> Ohio Rev. Code § 5122.31.

hospitalization has been sought . . . against the morbidly or maliciously curious who may, by taking advantage of the stigma which mental illness still connotes to many minds, cause social or economic injury to the individuals involved and their families. . . ."<sup>110</sup> A related protection against unnecessary publicity is the provision that the court shall exclude from the hearing all persons not having a legitimate interest.<sup>111</sup>

The right of habeas corpus is preserved,<sup>112</sup> and notice is given to interested parties in the event of transfer from one public hospital to another.<sup>113</sup> The preservation of the right of habeas corpus merely restates what is already the law. Notice in the event of transfer gives assurance to the patient that his relatives and friends know of his whereabouts and he will receive visits.

A disappointing feature of the new law is the failure to separate judicial hospitalization from incompetency. Indeterminate hospitalization by court order automatically results in incompetency.<sup>114</sup> This continuing archaism in the Ohio law conflicts with legislative trends in other states<sup>115</sup> and with the recommendations of leading mental health authorities.<sup>116</sup> The objection to a change in the law in this respect centered around the argument that mentally ill patients who require judicial hospitalization need protection from their improvident acts. This is premised on the theory that all mentally ill individuals who are indeterminately judicially hospitalized are in fact legally incompetent. The justification for the law has no more validity than the premise, and this premise is completely fallacious. It is widely recognized that many mentally ill persons subject to hospitalization by court order are quite competent.<sup>117</sup>

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<sup>110</sup> Draft Act, *op. cit. supra* note 102, at 35.

<sup>111</sup> Ohio Rev. Code § 5122.15.

<sup>112</sup> Ohio Rev. Code § 5122.30.

<sup>113</sup> Ohio Rev. Code § 5122.20.

<sup>114</sup> Ohio Rev. Code § 5122.36.

<sup>115</sup> Lindman and McIntyre, *op. cit. supra* note 80, at 221 and Table VIII 235-38.

<sup>116</sup> *Id.* at 228; see Guttmacher and Weihofen, *op. cit. supra* note 16, at 323-59. The Ohio version, which is retained for the most part in the new law, has received sustained criticism from a leading Ohio psychiatrist and lawyer. See Crawfis, "Civil Rights and Mental Hospitalization," 9 Clev.-Mar. L. Rev. 417 (1960); Crawfis, "Mental Competency and Mental Hospitals," 6 Clev.-Mar. L. Rev. 454 (1957). See also, "Constitutional Rights of the Mentally Ill," Hearings before the Sub-Committee on Constitutional Rights of the Committee on the Judiciary, U.S. Senate, 87th Congress, 1st Session, March 28-30, 1961, pages 183-99.

<sup>117</sup> See Guttmacher and Weihofen, *op. cit. supra* note 16, at 323-59. Different policy factors are involved between the issues of hospitalization and incompetency. Lindman and McIntyre, *op. cit. supra* note 80, at 219; 57 Ross, *op. cit. supra* note 80, at 981. A related inadequacy of the present law is that a guardian is not automatically appointed. See Ohio Rev. Code § 2111.02 (Page Supp. 1960); Lindman and McIntyre

While the unfortunate merger of incompetency and judicial hospitalization still exists, several important new provisions mitigate its harshness. Since only indeterminate hospitalization results in automatic incompetency, patients admitted voluntarily or pursuant to the involuntary nonjudicial procedures are not automatically incompetent. Similarly, automatic incompetency does not result from a court ordering a patient to a temporary observational and treatment period.<sup>118</sup> In judicial proceedings a patient should be able to avoid the undesirable effect of automatic incompetency by requesting voluntary admission during the temporary period.<sup>119</sup> Thus, automatic incompetency is designed only for patients who are mentally ill to the extent that they do not recognize their illness and who do not accept voluntary treatment after having received treatment for ninety days.

One criticism of the prior law was the difficulties created by automatic incompetency in the rehabilitation of a patient into the community prior to discharge. As a patient recovers from a mental illness and discharge becomes imminent, the better hospital procedure is to release the patient for extended periods of time but to continue to give treatment. These release periods also serve as a periodic check on the patient's progress in the community. Under the prior law a patient who had been judicially hospitalized could not apply for a competency adjudication until he received a final discharge.<sup>120</sup> Thus, a disability to enter into normal business affairs existed regardless of the extent of the patient's recovery or competency. The driver's license was suspended<sup>121</sup> which often created a transportation problem when requiring the patient to return to the hospital for treatment. As a result the valued goal of gradual rehabilitation was often frustrated since the patient was a "marked" person and could not attempt to follow a normal life while on trial visit. The hospital was often faced with the unfortunate choice of discharge without rehabilitation or retention in the hospital when only intermittent treatment was necessary and the patient was in fact competent.

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*op. cit. supra* note 80, at 222. Thus while the patient is protected by his legally created inability to transact business, situations may arise where no one is available to transact that business necessary for the maintenance of the estate. Such incompetency is sufficient grounds for the appointment of a guardian, Ohio Rev. Code § 5122.36.

<sup>118</sup> Ohio Rev. Code § 5122.15.

<sup>119</sup> See the discussion relating to notes 91-94, *supra*. This illustrates the importance of the mandatory temporary period and of the right to apply for voluntary admission under Ohio Rev. Code § 5122.15. The proper use of § 5122.15 should result in a substantial increase of patients hospitalized on a voluntary basis and automatic incompetency would be minimized.

<sup>120</sup> Ohio Rev. Code § 5123.51 (Page Supp. 1960), repealed.

<sup>121</sup> Ohio Rev. Code § 4507.161 (Page Supp. 1960), amended.

The new law permits an adjudication of competency prior to final discharge upon the court's own motion or upon written request by the hospital or the patient.<sup>122</sup> A patient's driver's license can be returned prior to final discharge, with or without an adjudication of competency, upon receipt of a statement by the hospital that "... such person's mental illness is not an impairment to such person's ability to operate a motor vehicle."<sup>123</sup> These provisions, if properly used, should correct the dilemmas that previously arose when rehabilitation was desired. The court has the authority to determine and redetermine the issue of competency or incompetency without regard to hospitalization.<sup>124</sup>

Hospitalized patients, who are not automatically incompetent because of judicial hospitalization, may be incompetent in fact. In such case a guardian may be appointed in an independent proceeding. If the competency issue arises where no determination has been previously made and the person was hospitalized, the question of the evidentiary value of hospitalization must be answered. This problem is not dealt with in the new law.<sup>125</sup>

#### MISCELLANEOUS PROVISIONS

The basic procedure for trial visit or release of the patient under the continuing jurisdiction of the hospital has been retained with several new qualifications. If a patient is hospitalized awaiting a judicial hearing, any release prior to the hearing must have the approval of the court having jurisdiction.<sup>126</sup> This provision permits the court to control the patient until it has had an opportunity to hear some evidence and to make a preliminary determination of the case. Release on trial visit may be for a relatively short period of time or it may be for an indefinite time. A new provision requires annual re-examination to determine if continued hospitalization is

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<sup>122</sup> Ohio Rev. Code § 5122.36. Patients hospitalized under the prior law may also have an adjudication of competency. Ohio Rev. Code § 5122.38.

<sup>123</sup> Ohio Rev. Code § 4507.161 (Page Supp. 1960), amended. The provision may seem ambiguous as to whether an adjudication of competency must precede the return of the license but read together with Ohio Rev. Code § 4507.08(C), as amended, it is clear the legislative intent was to provide an alternate method, competency or the written statement by the head of the hospital.

<sup>124</sup> See Lindman and McIntyre, *op. cit. supra* note 80, at 228, for the desirable policy factors in favor of such authority.

<sup>125</sup> Future legislation should attempt to solve the evidence question. 57 Ross, *op. cit. supra* note 80, at 994.

<sup>126</sup> Ohio Rev. Code § 5122.23. The approval is not necessary once the court has had a hearing.

necessary.<sup>127</sup> A similar protection against patients being relegated to the back wards of the hospital is the requirement for re-examination of patients "... as frequently as practicable ... ." <sup>128</sup>

The jurisdictional aspects received very little change. If a patient is in a hospital, the probate court of the hospital district is required to hold the hearing upon request of the court where the affidavit is filed.<sup>129</sup> This was previously authorized but was permissive,<sup>130</sup> and evidence was presented that some courts located in the hospital district occasionally refused such cases. Under these circumstances the court in the hospital district has easier access to the patient and to medical evidence.

Several important provisions were added to the discharge procedure. Previous distinctions between discharges as improved, unimproved or recovered<sup>131</sup> have been deleted. The patient is discharged when "... the conditions justifying involuntary hospitalization no longer obtain ... ." <sup>132</sup> Upon discharge the hospital must notify the court which ordered hospitalization.<sup>133</sup> Discharge automatically restores competency.<sup>134</sup> A guardianship based upon the automatic incompetency created by judicial hospitalization may be terminated upon motion and evidence of a final discharge.<sup>135</sup>

The new provisions add needed clarity to the patient's competency status upon discharge. The prior law required discharge based upon recovery as a condition to restoring competency automatically.<sup>136</sup> The distinction had little foundation in practice and often created unnecessary hardship.<sup>137</sup> The theoretical justification for merging restoration of competency and discharge is as unreal as the justification for merging incompetency and judicial hospitalization.<sup>138</sup> A patient may be in fact incompetent even though discharged from a hospital. The only proper solution is to separate incompetency from hospitalization.

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<sup>127</sup> The section seems permissive but the discretion applies to the first re-examination. The mandatory language is "... and not less frequently than annually thereafter. . . ." Ohio Rev. Code § 5122.23.

<sup>128</sup> Ohio Rev. Code § 5122.21.

<sup>129</sup> Ohio Rev. Code § 5122.35.

<sup>130</sup> See Ohio Rev. Code § 5123.30 (Page Supp. 1960), repealed.

<sup>131</sup> Ohio Rev. Code § 5123.50 (Page Supp. 1960), repealed.

<sup>132</sup> Ohio Rev. Code § 5122.21.

<sup>133</sup> *Ibid.*

<sup>134</sup> Ohio Rev. Code § 5122.36.

<sup>135</sup> *Ibid.*

<sup>136</sup> Ohio Rev. Code § 5123.50 (Page Supp. 1960), repealed.

<sup>137</sup> See 9 *Crawfis, op. cit. supra* note 116.

<sup>138</sup> See the discussion relating to notes 111-13, *supra*.

## CONCLUSION

The new law provides an indispensable tool in the implementation of Ohio's modern mental health program. Many of the new provisions have value from their mere enactment. For example, it is hoped the provisions relating to patient's rights will create a more sympathetic public opinion and will generally encourage patients to seek voluntary treatment at the earlier stages of mental illness. The effectiveness of many provisions will depend upon the dedicated effort of those within the medical and legal professions who work in and are concerned with the mental health program.

The legislature has provided a sound foundation upon which to build. The new law, with the exception of the treatment of competency, ranks with the best mental health laws in the nation. But it is not the final answer. The modern perspective of hospitalization and treatment of the mentally ill is in its infancy. Psychiatric techniques may be discovered in this decade which will completely antiquate Ohio's new effort. Those in the mental health program must be cautious against complacency. Change must be prompt and welcomed. An obstructive law in this field is less tolerable than in other fields because a lack of the best treatment available adds to the tragic misery and despair of those afflicted with mental illness.